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January 20, 2016

VIA ELECTRONIC SUBMISSION

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Comments on Tennessee's Section 1115 Medicaid Waiver Extension Request (Project No. 11-W-00151/4)

Dear Secretary Burwell:

The Tennessee Justice Center (TJC) is a public interest law firm advocating on behalf of low-income and uninsured Tennessee families. The Tennessee Health Care Campaign (THCC) is a nonprofit consumer health advocacy group. On behalf of TJC and THCC, we jointly submit these comments concerning the State of Tennessee's request, submitted December 22, 2015, to extend its current Section 1115 Medicaid waiver, known as TennCare II.[1] The state seeks a five year extension of the current waiver.

While we supported the original TennCare waiver and have continued over the intervening decades to support important aspects of the program, we respectfully submit that the current application is not approvable its present form. As explained below, three factors preclude its approval:

1) Tennessee's failure to conform its Medicaid program to fundamental requirements of federal law governing eligibility and enrollment leave TennCare with an aberrant design that makes the program inappropriate for the testing, demonstration and evaluation of Medicaid policy.
2) Tennessee's request would extend the 22-year old waiver of the state's compliance with the retroactive eligibility requirements of Section 1902(a)(34) of the Social Security Act [42 U.S.C. § 1396a(a)(34)] and 42 C.F.R. § 435.915, a waiver that can no longer meet the requirements of Section 1115.
3) Tennessee requests a five year extension, rather than the three year maximum prescribed by the Centers for Medicare and Medicaid Services (CMS). The request does not meet the criteria for a five year "Fast Track" extension.

[1] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/ta-tenncare-ii-pa-12222015.pdf.

A. The State's current waiver and its requested extension

Tennessee's comprehensive Section 1115 Medicaid waiver was originally approved in 1993 and implemented in 1994 under the name "TennCare." TennCare substantially expanded coverage to groups that were not covered under traditional Medicaid categories, and it enrolled all beneficiaries in mandatory managed care for most services.

The waiver was substantially revised under the name "TennCare II." Significantly, expanded eligibility was almost entirely eliminated and coverage became more restrictive than it had been before 1994. It is this more restricted program that is the subject of the pending extension request. Tennessee remains unwilling to restore the expanded coverage that was the predicate for the original TennCare waiver, even though such coverage is now authorized and generously funded under the Affordable Care Act.

Since its original approval in 1993, Tennessee's TennCare waiver has included a waiver of compliance with the retroactive eligibility requirements of 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.915 [formerly designated as 42 C.F.R.§ 435.914]. That provision was initially justified as necessary to support both of TennCare's major innovations. One innovation was the then-novel use of mandatory managed care to deliver high quality acute medical services to the entire Medicaid population. The state reasoned that retroactive coverage was incompatible with the demonstration because managed care organizations could not retroactively manage care for patients who were not enrolled at the time care was provided.

TennCare's other major innovation was the offer of coverage to uninsured populations who were not eligible under traditional Medicaid rules. A hypothesis that the state sought to evaluate was that the extension of coverage would make it possible for newly eligible enrollees to obtain timely preventive care, thereby reducing overall medical costs. The state argued that the waiver of retroactive coverage would serve that goal by incentivizing individuals to enroll as soon as they became eligible, rather than delaying enrollment, and foregoing preventive care, until they became acutely ill.

The waiver was last extended for a three year period that runs from July 1, 2013 through June 30, 2016. Paragraph 9 of the current waiver extends the waiver of compliance with 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.914, "To enable the state not to extend eligibility prior to the date that an application for assistance is made." Paragraph 9 further provides that "This waiver authority will expire at the end of the extension period of the demonstration, June 30, 2016, unless otherwise approved [pursuant to the standard extension application and transparency requirements]."[2]

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[2] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/TennCare-II/tn-tenncare-ii-waiver-list-07012013-06302016-4.pdf.

Paragraph 68 of the Special Terms and Conditions concerns "Evaluation of Eligibility and Enrollment Systems," and provides:[3]

> The state shall propose data collection and reporting measures designed to assess the ongoing need for retroactive Medicaid eligibility after changes specified in the Affordable Care Act are effectuated. The interim evaluation report required in paragraph 8 (*Extension of the Demonstration*) and paragraph 70 (*Interim Evaluation Reports*) should contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange. CMS may issue further guidance to the state on the specific performance measures. The state may include the following areas of interest in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other relevant data.
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> a. Evaluation of eligibility determinations by type, e.g., application, redetermination, transfer to the Exchange.
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> b. Evaluation of Medicaid denial and termination reasons.
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> c. Evaluation of average application processing times and timeliness.
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> d. Evaluation of reasons for disenrollment and internal churn.
>
> e. Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable.

On December 22, 2015, Governor Bill Haslam submitted a request to extend the current TennCare II Waiver for five years. The application requested, at page 25, that the current waiver be extended without any changes other than the removal of the sentence in Paragraph 9 that provides that the waiver of retroactive eligibility shall expire on June 30, 2016.

As required by Paragraph 70 of the present waiver, the extension request includes an interim report purporting to evaluate the results of the current demonstration. However, the report evaluates none of the matters specified in Paragraph 68 relating to TennCare's eligibility determination processes and the relationship of those processes to retroactive eligibility. The request states only that, "The state contracted with Manatt, Phelps & Phillips, LLP, to conduct this study, which is currently being finalized."

B. An extension of the TennCare waiver is not approvable under Section 1115 of the Act.

Section 1115(a)(1) authorizes the Secretary to waive any requirement of Section 1902 to the extent and for the period necessary to enable a state to implement an experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the

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[3] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/TennCare-II/tn-tenncare-ii-stc-07012013-06302016-3.pdf.

objectives of Title XIX. As you know, Section 1115 was intended to allow only for "experimental projects designed to test out new ideas and was for dealing with the problems of public welfare recipients." Such projects are to be "selectively approved," "designed to improve the techniques of administering assistance and related rehabilitative services," and "usually cannot be statewide in operation."[4] As has been held:

> The statute was not enacted to enable states to save money or to evade federal requirements but to 'test out new ideas and ways of dealing with the problems of public welfare recipients.' [citation omitted] … A simple benefits cut, which might save money, but has no research or experimental goal would not satisfy the requirement.

Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994).

Consistent with these limitations on Secretarial waiver authority, CMS has issued general criteria that determine whether Medicaid program objectives are met by a proposed 1115 waiver. These criteria, which are posted at www.medicaid.gov, include whether the demonstration will:

1. increase and strengthen overall coverage of low-income individuals in the state;
2. increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
3. improve health outcomes for Medicaid and other low-income populations in the state; or
4. increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Tennessee's requested extension does not satisfy these criteria.

1) Tennessee cannot justify an extension of its 1115 waiver while TennCare fails to conform to fundamental requirements of Title XIX and the Affordable Care Act (ACA) relating to eligibility and enrollment.

Among all of the states, Tennessee is unique in the extent of its failure to administer a Medicaid eligibility and enrollment process that complies with Title XIX and the requirements of the Affordable Care Act (ACA) that ensure seamless coverage between Medicaid and the insurance Exchange. CMS can confirm that TennCare's eligibility and enrollment process is plagued by a combination of administrative deficiencies and policy choices that result in pervasive noncompliance with federal law.

The state failed in its effort to develop the TennCare Eligibility Determination System (TEDS) to meet the ACA's 2013 deadline for reform of state IT systems. Tennessee still lacks an automated eligibility determination system, and it does not anticipate that it will have one until, at best, 2018. This problem is compounded by state policy decisions, implemented in violation of

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[4] S. Rep. No. 87-1589, at 19-20, reprinted in 1962 U.S.C.C.A.N.1943, 19610-62. See also H.R. Rep. No. 3982, pt. 2 at 307-08 (1981) ("States can apply to HHS for a waiver of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries.")

federal law, that obstruct and delay TennCare enrollment and prevent seamless coverage transitions between TennCare and the Exchange:

- TennCare explicitly refuses to comply with the requirements of 42 U.S.C. § 18083 and 42 C.F.R. §435.907(a) that it accept applications online or by phone, mail, in person or by other commonly available electronic means (e.g., fax and email). In January 2014, Tennessee closed all state application portals and has since required all applicants to apply via the Federal Exchange, which can accept applications only online, by phone or by mail. (The state makes exceptions for those seeking long term supports and services, or enrollment in a Medicare Savings Program, but even they do not have access to all modes of application prescribed by the ACA.) In finding TennCare in violation of federal laws requiring the timely processing of applications, a federal court found in September 2014 that, "The Federal Exchange was not designed to replace the State's Medicaid application process, and it is not particularly surprising that the system has had operational problems and difficulties in handling that task." *Wilson v. Gordon*, 2014 U.S. Dist. LEXIS 122010 (M.D. Tenn. September 2, 2014) Nearly a year and a half after that ruling, and even longer since CMS cautioned the state that forcing applicants to rely solely on the Federal Exchange was improper, TennCare still refuses to accept its responsibility to accept and process applications. Tennessee remains an outlier as the only state that abdicates to the Federal Exchange functions that, under the law, are fundamental responsibilities of the single state agency.
- TennCare remains out of compliance with the provisions of 42 U.S.C. § 1396(a)(8) and 42 C.F.R. § 435.912 requiring the prompt processing of applications and timely determination of eligibility.
- TennCare does not comply with the "no wrong door" requirement of 42 U.S.C. § 18083 and 42 C.F.R. § 435.911 that it assess an applicant's eligibility under all potential categories of coverage.
- TennCare does not determine whether applicants found ineligible for TennCare are eligible for other insurance affordability programs, as required by 42 C.F.R. §§ 435.911 and 435.1200, and it does not transfer applicants' files for enrollment in such other programs.
- TennCare refuses to comply with 42 U.S.C. § 1396a(a)(47)(B) and 42 C.F.R. §435.1110, which require states to authorize hospitals to presumptively enroll MAGI-eligible individuals in their Medicaid programs.

These fundamental violations of federal law are well documented in CMS records and court filings. Tennessee has not only refused to correct these violations. The state has been unwilling even to submit to CMS an approvable mitigation plan that would lessen the adverse impacts of TennCare's noncompliance on applicants, enrollees and providers. CMS requested such a plan in June 2014, but TennCare's response was insufficient, and efforts to elicit an appropriate plan from the state have not been successful.

TennCare's pervasive noncompliance precludes approval of its waiver extension requests for several reasons:

> *First*, Tennessee's actions, taken without Secretarial approval, to dispense with federal eligibility and enrollment requirements violate a cardinal condition of every Section 1115 waiver, including the current TennCare II waiver. That is the proviso that:
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> > All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following list [of provisions waived] shall apply to all TennCare II populations identified in paragraph 17 (Eligibility) of the Special Terms and Conditions.
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> Tennessee's unwillingness to be bound by this most basic condition of the Section 1115 waiver forecloses the possibility that an extension of the waiver will achieve its intended demonstration purposes.
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> *Second*, Tennessee's unwillingness or inability to meet federal requirements over a period of years creates fatal uncertainty about its capacity to implement the terms and conditions of a waiver. The state's conduct leaves no room for confidence that the state will administer a waiver program as designed, or fulfill the evaluation obligations that are integral to the purpose of a demonstration waiver.
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> *Third*, Tennessee's unauthorized deviations from the requirements of Title XIX have produced a program that is unique, and that differs so significantly from other Medicaid programs that the results of an 1115 demonstration waiver would have little value or transferability to Medicaid programs that operate in conformity with Title XIX.

To prevent the disruption of enrollee services and dislocations in the Tennessee health care system, we propose the grant of a one-year extension. The extension should be contingent upon the state's submission of a plan that will either wind down the program by June 30, 2017 or achieve compliance with mandatory federal eligibility and enrollment requirements well before then. No extension should be granted beyond that date unless and until the state actually achieves such compliance.

2) <u>An extension of the TennCare waiver that includes ongoing waiver of retroactive eligibility would defeat the purposes of Title XIX and is not approvable under Section 1115.</u>

As noted above, the state's extension request seeks the continuation for another five years of the waiver of the state's compliance with the retroactive eligibility requirements of Section 1902(a)(34) of the Social Security Act and 42 C.F.R. § 435.914. That request is not approvable because:

- Extending the waiver of retroactive eligibility would not further the purposes of the Act.
- After having been part of TennCare for 22 years, there is nothing concerning this policy that remains to be tested or evaluated.
- The state has not fulfilled the evaluation requirements of the present waiver as applied to the retroactive eligibility provision. The state has provided no evidence proving the original hypothesis that the waiver would cause newly eligible individuals to enroll and seek care more quickly.
- The waiver of retroactive eligibility causes serious, ongoing harm to TennCare enrollees and Tennessee health care providers.

(a) *Extending the waiver of retroactive eligibility would not further the purposes of the Act, as required for approval under Section 1115.*

Extension of the waiver of retroactive eligibility serves neither the general purposes of Title XIX nor the specific purposes of Section 1902(a)(34). The purpose of Title XIX, as stated in Section 1902 of the Social Security Act, is "to furnish … medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services." The Act originally included a provision authorizing retroactive medical assistance at state option. Congress made the requirement mandatory in 1972 by enacting Section 1902(a)(34) in order to

> … protect persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements or because the sudden nature of their illness prevented their applying.[5]

Another important purpose of retroactive eligibility was to encourage providers to furnish necessary medical assistance during the retroactive period.[6] *Price v. Medicaid Director of Ohio,* 310 F.R.D. 345 (S.D. Ohio 2015).

Waiver of Section 1902(a)(34) can no longer be justified on the grounds on which it was originally authorized. Comprehensive Medicaid managed care, which was largely untested two decades ago, is now the norm. Other states successfully administer capitated managed care

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[5] Staff of S. Comm. on Finance, 92d Cong., Rep. to Accompany H.R. 1 to Amend the Social Security Act, and for other purposes, at 209, available at: https://ssa.gov/history/pdf/Downey%20PDFs/Amendments%20to%20the%20Social%20Security%20Act%201969-1972%20Vol.%203.pdf.

[6] *Amendments to the Social Security Act, 1969-1972: Hearing on H.R. 17550 Before the S. Comm. on Fin., 91st Cong. 1262 (1970) (Statement of Elliot L. Richardson, Secretary, Dept. of Health, Education, and Welfare), available at:* https://www.ssa.gov/history/pdf/Downey%20PDFs/Amendments%20to%20the%20Social%20Security%20Act%201969-1972%20Vol.%208.pdf;

programs without needing to waive retroactive coverage. Indeed, when Congress adopted the 1997 amendments to Title XIX that authorized the widespread use of Medicaid managed care, it left unchanged the retroactive eligibility requirements of Section 1902(a)(34), recognizing that there was no incompatibility between the two policies.

The other justification for the waiver of retroactive eligibility, which was to incentivize formerly ineligible individuals to enroll as soon as they became eligible, no longer exists either. The original demonstration waiver tested the hypothesis that expanded eligibility and incentives for prompt enrollment would foster prevention and, ultimately, the avoidance of preventable medical costs. But Tennessee dropped almost all of the expansion population over a decade ago, and the only waiver-eligible enrollees still on the program are a very small group of children who would be eligible in other states under CHIP or traditional Spend-Down Medicaid rules. In contrast to where Tennessee stood two decades ago, as an innovator in expanding coverage to the uninsured, the state now refuses to provide Medicaid to the new eligibility groups whose coverage is mandated by the Affordable Care Act. And by persistently refusing to comply with federal requirements that facilitate the timely enrollment of eligible individuals, Tennessee now delays eligible individuals from enrolling in TennCare, which is exactly the opposite result that the waiver of retroactive eligibility originally sought to achieve.

Even if Tennessee were not administering its Medicaid program in a manner that is at odds with the stated goals of the waiver of retroactive eligibility, other changed circumstances would make extension of the waiver inappropriate. Since the TennCare waiver was initially approved, Congress has taken a very different approach to incentivizing early enrollment and preventive care. While leaving Section 1902(a)(34) in effect, Congress included in the Affordable Care Act a variety of measures to encourage prompt Medicaid enrollment without depriving enrollees of retroactive coverage. Federal policy, as established by the ACA, now relies on tax penalties, streamlined eligibility and enrollment, and funding for outreach and enrollment assistance. In present circumstances, the continued waiver of Section 1902(a)(34) for the traditional Medicaid population, as Tennessee requests, no longer serves any legitimate research or demonstration purpose.

(b) *After having been part of TennCare for 22 years, there is nothing concerning the waiver of retroactive eligibility that remains to be tested or evaluated.*

Section 1115(a)(1) authorizes the grant of a waiver only "for the period [the Secretary] finds necessary to enable" a state to conduct an experimental, pilot, or demonstration project. That period has passed. The state's extension request contains no attempt to link the continued waiver of Section 1902(a)(34) to any policy or hypothesis that requires further testing or evaluation. The request contains no purported justification for continuing to waive retroactive eligibility. In the state's description of the "Future Goals of the Program", at pages 22-24, there are no anticipated innovations and no focus of future effort that are in any way related to, much less reliant upon, the waiver of retroactive eligibility.

(c) *The state has not fulfilled the evaluation requirements of the present waiver as applied to the retroactive eligibility provision.*

Paragraph 68 of the current waiver, quoted above, required the state to include an "Evaluation of Eligibility and Enrollment Systems" in the interim report that accompanied the extension request. That report was to "contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid and the Exchange," explicitly including "Evaluation of average application processing times and timeliness" and "Evaluation of seamless transition between Medicaid, CHIP or the Exchange, as applicable." The purpose was to enable CMS to determine whether the ongoing waiver of retroactive eligibility meets the purposes of Section 1115

As noted above, the four page interim evaluation report that is included at page 35 of the extension request is devoid of any documentation, data or evaluation of TennCare eligibility and enrollment systems. The state has contracted with Manatt, Phelps & Phillips, LLP to conduct a study, which is said to be in the process of being finalized. The state's failure to arrange for timely evaluation of the waiver makes clear that evaluation is an afterthought, rather than the central purpose that it must be to warrant an 1115 waiver.

(d) *The waiver of retroactive eligibility causes serious, ongoing harm to TennCare enrollees and Tennessee health care providers.*

In assessing the effects of waiving retroactive eligibility, it is important to take into account state rules that impose stringent requirements governing the submission of TennCare applications for purposes of determining the effective date of coverage. TennCare Rule 1200-13-13-.02(5)(b) provides that the effective date of eligibility for applicants other than SSI beneficiaries approved by the Social Security Administration is "the date of the application or the date of the qualifying event (such as the date that a spend-down obligation is met), whichever is later." TennCare Rule 1200-13-13-.01 (22) defines "completed application" as follows:

> COMPLETED APPLICATION is an application where:
> (a) All required fields have been completed;
> (b) It is signed and dated by the applicant or the applicant's parent or guardian;
> (c) It includes all supporting documentation required by the [Tennessee Department of Human Services] or the [TennCare] Bureau to determine TennCare eligibility, technical and financial requirements as set out in these rules: and
> (d) It includes all supporting documentation required to prove TennCare Standard medical eligibility as set out in these rules.[7]

These requirements for the completion of an application often impede even the most diligent of applicants and their assisters in establishing the date of application and, hence, the effective date of coverage. When combined with the effects of the state's pervasive

[7] *See*: http://share.tn.gov/sos/rules/1200/1200-13/1200-13-13.20150930.pdf.

noncompliance with federal eligibility and enrollment requirements, described above, the TennCare rules commonly result in gaps in coverage between when an applicant first tries to apply and when she is able to submit a "completed application." That is especially true for individuals with disabilities, to whom the state provides little meaningful accommodation, and for households with complex composition, mixed citizenship status or varied income sources.

In these circumstances, the waiver of retroactive eligibility harms TennCare applicants and enrollees in multiple ways:

- Providers are reluctant to treat applicants until they are enrolled in TennCare, due to well-founded concerns that coverage will not be effective until a date after that on which treatment is rendered. These treatment delays can have serious adverse health consequences.
- Applicants who do manage to obtain care before enrollment are most typically those who experience catastrophic medical emergencies and are hospitalized under the Emergency Medical Treatment and Labor Act (EMTALA). Impediments to the submission of completed applications, combined with the waiver of retroactive eligibility, leave these patients' families burdened with ruinous medical debts, and their providers saddled with large amounts of uncompensated care.
- Largely because delays in the effective date of coverage leave so many providers unpaid, a great many providers, especially physicians, perceive TennCare as an unreliable payer. This is a major factor contributing to TennCare's rank as one of the five worst Medicaid programs in the nation in terms of physician participation rates.[8] By discouraging provider participation, the waiver of retroactive eligibility thus continues to adversely affect enrollees' access to care long after they manage to overcome the enrollment and eligibility barriers that delay coverage.

The waiver of retroactive eligibility causes significant financial harm to health care providers, especially to hospitals that are required by EMTALA to extend hundreds of millions of dollars in uncompensated emergency care that TennCare should cover. This financial burden has serious implications for the hospitals' employees and the communities they serve. Many, particularly in rural areas, are already hard pressed by Tennessee's refusal to expand Medicaid, and by possible reductions in Low Income Pool (LIP) funds. According to audited financial reports submitted to the Tennessee Department of Health, 54 of Tennessee's 121 acute care hospitals are at risk of closing or substantially cutting services due to financial pressures.[9]

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[8] A. Goodnough, "Shortage of Doctors Accepting Medicaid," *New York Times* (November 28, 2013) available at: http://www.nytimes.com/interactive/2013/11/28/us/Shortage-of-Doctors-Accepting-Medicaid.html?ref=us.

[9] *See*: https://tnjustice.org/wp-content/uploads/2013/01/Medicaid-Reform-is-a-Lifeline-for-Tennessees-Hospitals-FINAL-unbranded.pdf.

The recent experience of a Tennessee Justice Center client illustrates the ways in which TennCare policies combine with the waiver of retroactive eligibility to inflict serious harm. The client is a young mother who lapsed into a coma after suffering anti-NDMA receptor encephalitis, caused by an ovarian tumor. She required emergency inpatient hospital care lasting seven weeks. Though she was MAGI-eligible for TennCare from date of admission, TennCare's refusal to implement hospital presumptive eligibility barred the admitting hospital from establishing her coverage at the time of her admission. Her husband, who is a disabled veteran, vainly sought to apply in person on her behalf at the Tennessee Department of Human Services, and he received no offer of assistance or accommodation of his disabilities. Weeks into her hospitalization, the state finally accepted an application for long terms supports and services but deemed it incomplete and refused to process the patient's eligibility for all potential sources of coverage, including MAGI. Because she lacked insurance, once she had been discharged from the hospital, the patient could not get timely follow-up care and rehabilitation services. She finally obtained TennCare coverage through the Federal Exchange, but only after accruing medical bills of more than $900,000. The family will have to declare bankruptcy, and the two hospitals and numerous physicians that treated her will go unpaid. The waiver of retroactive eligibility in this and similar cases serves no legitimate purpose under Section 1115, other than to demonstrate that the waiver undermines the goals of Title XIX.

C. In no event should the TennCare waiver be extended for more than three years.

As explained above, we respectfully urge you to reject Tennessee's waiver extension request in its present form, and to provisionally extend a revised TennCare waiver for only one year. In any event, there are no circumstances in which it would be appropriate to grant the state a waiver that exceeds the three year period ordinarily prescribed by CMS guidelines. Tennessee cannot qualify for a five year extension under CMS's "Fast Track" Federal Review Process for Section 1115 Extensions.[10] Such extensions are only available to states that:

> … have demonstrations in compliance with reporting deliverables and that have positive monitoring and evaluation results that indicate that the objectives of the demonstration and of the Medicaid/CHIP program have been achieved…

As explained above, Tennessee fails to meet this requirement.

Three years is a sufficient period to implement and evaluate any innovations. And given Tennessee's unwillingness to comply with legal requirements, it is imprudent to extend the state such a lengthy exemption from federal laws.

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[10] CMCS Informational Bulletin, "Implementation of a 'Fast Track'Federal Review Process for Section 1115 Medicid and CHIP Demonstration Extensions," July 24, 2015, posted at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib07242015-fast-track.pdf.

Thank you for your consideration of our concerns, and please do not hesitate to contact us if you or your staff have any questions or would like documentation of any of the matters discussed above.

Respectfully submitted,

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